California Health Benefit Exchange

Board Members
Diana S. Dooley, Chair
Kimberly Belshé Paul Fearer
Susan Kennedy Robert Ross, MD

Executive Director
Peter V. Lee

November 16, 2012

ADVANCE NOTICE OF INTENT TO FILE EMERGENCY REGULATIONS

This notice is sent in accordance with Government Code Section 11346.1(a)(2), which requires that State of California agencies give a five working day advance notice of intent to file emergency regulations with the Office of Administrative Law (OAL). The California Health Benefit Exchange ("Exchange") intends to file an Emergency Rulemaking package with the Office of Administrative Law (OAL) that affects the Exchange's contracting process and standards for selecting and contracting with Qualified Health Plans for the offering of health insurance in the Health Benefit Exchange. As required by subdivisions (a)(2) and (b)(2) of Government Code Section 11346.1, this notice appends the following: (1) the specific language of the proposed regulation and (2) the Finding of Emergency, including specific facts demonstrating the need for immediate action, the authority and reference citations, the informative digest and policy statement overview, attached reports, and required determinations.

The Exchange plans to file the Emergency Rulemaking package with OAL at least five working days from the date of this notice. If you would like to make comments on the Finding of Emergency or the proposed regulations (also enclosed), they must be received within five calendar days of the Exchange's filing at OAL by both the Exchange and the Office of Administrative Law. Responding to comments at this point in the process is strictly at the Exchange's discretion.

Comments should be sent simultaneously to:

California Health Benefit Exchange
Attn: Andrea Rosen
560 J Street, Suite 290
Sacramento, CA 95814

Office of Administrative Law
300 Capitol Mall, Suite 1250
Sacramento, CA 95814

Please note that this advance notice and comment period is not intended to replace the public's ability to comment once the emergency regulations are approved. The Exchange will hold a public hearing and 45-day comment period within the 180 day certification period following the effective date of the emergency regulations.

Please contact Andrea Rosen at 916-323-3502 or info@hbex.ca.gov if you have any questions concerning this Advance Notice.

FINDING OF EMERGENCY

The Director of the California Health Benefit Exchange finds that an emergency exists and that this proposed emergency regulations is necessary to address a situation that calls for immediate action to avoid serious harm to the public peace, health, safety or general welfare.

DEEMED EMERGENCY

The Exchange may "Adopt rules and regulations, as necessary. Until January 1, 2016, any necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedures Act. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare." (Gov. Code, § 100504, subd. (a)(6).)

AUTHORITY AND REFERENCE

Authority: Government Code Section 100504.
Reference: Government Code Sections 100502, 100503, 100504, 100505, and 100507.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Existing law, the California Patient Protection and Affordable Care Act, established the California Health Benefit Exchange. The Exchange is responsible for arranging and contracting with health insurance issuers to provide affordable, quality health insurance coverage to qualified individuals and qualified employers through the Exchange. (Gov. Code, § 100500 et seq.) In order to provide health care coverage through the Exchange, the Exchange must contract with health insurance issuers through a competitive selection process based on uniform standards and criteria that must be developed by the Exchange. (Gov. Code, §§ 100503, 100504).

The proposed regulations will provide the public with the clear standards and guidelines the Exchange will use in its selection of health insurance issuers for participation as qualified health plans in the Exchange. The regulations will ensure that all health plan issuers are on a level playing field and have an equal opportunity to be selected for participation in the Exchange. Additionally, these regulations will increase transparency in the Exchange's process for selecting qualified health plans, which will result in greater consumer confidence in the Exchange.

LOCAL MANDATE

This proposal does not impose a mandate on local agencies or school districts.

FISCAL IMPACT ESTIMATES

This proposal does not impose costs on any local agency or school district for which reimbursement would be required pursuant to Part 7 (commencing with Section

17500) of Division 4 of the Government Code. This proposal does not impose other nondiscretionary cost or savings on local agencies.

COSTS OR SAVINGS TO STATE AGENCIES

The proposal results in additional costs to the California Health Benefit Exchange, which is funded by federal grant money. The proposal does not result in any costs or savings to any other state agency.

TITLE 10. INVESTMENT
CHAPTER 12. CALIFORNIA HEALTH BENEFIT EXCHANGE (§6400 ET SEQ.)

ARTICLE 2: DEFINITIONS

SECTION 6410: DEFINITIONS

As used in this Chapter, the following terms shall mean:

340B Entity: A "covered entity" as defined in Public Health Service Act Section 340B(a)(4), 42 U.S.C. 256b(a)(4).

Accountable Care Organization (ACO): A voluntary group of physicians, hospitals and other health care providers that are willing to assume responsibility and some financial risk for the care of a clearly defined patient population attributed to them on the basis of patients' use of primary care services. Characteristics of an ACO may include robust use of Electronic Health Record infrastructure, defined quality metrics including outcomes, shared savings formulas affecting reimbursement, coordinated care requirements or pay for performance reimbursement components.

Alternate Benefit Plan Design: A QHP proposed benefit plan design which features different cost-sharing requirements than the Exchange's Standardized Qualified Health Plan Designs.

Benefit Plan Requirements: Coverage that provides for all of the following as under 45 CFR § 156.20:

(a) The essential health benefits as described in Section 1302(b) of the Affordable Care Act;
(b) Cost-sharing limits as described in Section 1302(c) of the Affordable Care Act; and
(c) A bronze, silver, gold, or platinum level of coverage as described in section 1302(d) of the Affordable Care Act, or is a catastrophic plan as described in Section 1302(e) of the Affordable Care Act.

Bidder: A Health Insurance Issuer seeking to enter into a Qualified Health Plan contract.

Board: The Board of the California Health Benefit Exchange, established by Government Code 100500.

CAHPS: Consumer Assessment of Healthcare Providers and Systems. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a multi-year initiative of the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers' experiences with health care. CAHPS develops surveys that are taken by hospitals, health plans, and home health agencies and are designed to measure patient experience with these entities.

CalHEERS: The California Healthcare Eligibility, Enrollment and Retention System, created pursuant to Government Code 100502 and 100503, as well as 42 U.S.C. 18031, to enable enrollees and prospective enrollees of QHPs to obtain standardized comparative information on the QHPs as well as apply for eligibility, enrollment, and reenrollment in the Exchange.

California Health Benefit Exchange or Exchange: The entity established pursuant to Government Code 100500. The Exchange also does business as and may be referred to as Covered California.

Certified QHP: Any QHP that is selected by the Exchange and has entered into a contract with the Exchange for the provision of health insurance coverage for enrollees who purchase health insurance coverage through the Individual and/or Small Business Health Options Program (SHOP) Exchanges.

Cost-share: Any expenditure required by or on behalf of an enrollee with respect to receipt of Essential Health Benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.
Day: A calendar day unless a business day is specified.

EPO: An Exclusive Provider Organization, as defined in California Code of Regulations, title 10, Section 2699.6000(r).

Essential Community Providers: Providers that serve predominantly low-income, medically underserved individuals, as defined in 45 C.F.R. 156.235.

Essential Health Benefits: The benefits listed in 42 U.S.C. 18022, 2012 Cal. Stat. 854 (AB 1453), and 2012 Cal. Stat. 866 (SB 951).

Evidence-Based Medicine: The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.

Exchange Evaluation Team: The team selected by the Exchange to conduct the QHP bid response evaluation by consensus and assess whether the response is responsive and may proceed to the evaluation of the Response to Requirements.

Executive Director: The Executive Director of the Exchange.

Federally-Qualified Health Center (FQHC): Federally-Qualified Health Center has the same meaning as that term is defined in Public Health Service Act Section 1905(l)(2)(B) (42 U.S.C. 300w-5(l)(2)(B)).

Geographic Service Area: A defined geographic area within the State of California that a proposed QHP proposes to serve and is approved by the applicable State Health Insurance Regulator to serve.

Health Insurance Issuer: Health Insurance Issuer has the same meaning as that term is defined in 42 U.S.C. 300gg-91 and 45 C.F.R. 144.103. Also referred to as "Health Issuer" or "Issuer."

Health Maintenance Organization (HMO): A Health Care Service Plan (as that term is defined in Health & Safety Code 1345) holding a current license from and in good standing with the California Department of Managed Health Care.

HEDIS: Health Effectiveness Data and Information Set, a set of managed care performance measures developed and maintained by the National Committee for Quality Assurance.

HSA: Health Savings Account, as defined in 26 U.S.C. 223.

Independent Practice Association (IPA): An IPA is a legal entity organized and directed by physicians in private practice to negotiate contracts with Health Insurance Issuers on their behalf.

Individual and Small Business Health Options Program (SHOP) Exchanges: The programs administered by the Exchange pursuant to 2010 Cal. Stat. 655 (AB 1602), the federal Patient Protection Affordable Care Act (Public Law 111-148) and other applicable laws to furnish and to pay for health insurance plans for Qualified Individuals and Qualified Employers.

Ineligible Bidder: A prospective Bidder who is not in good standing with the applicable State Health Insurance Regulator, or does not meet the qualifications for consideration as a Qualified Health Plan under this Chapter, or has not provided complete responses or conforming responses to the QHP solicitation.

Initial Open Enrollment Period: The initial period in which Qualified Individuals may enroll in QHPs, from October 1, 2013 to March 31, 2014, subject to 45 C.F.R. 155.410(b).

Internet Web Portal: The web portal made available through a link on the Exchange's website, www.healthexchange.ca.gov, through which the Exchange will make the Solicitation available electronically.

Level of Coverage: One of four standardized actuarial values and the catastrophic level of coverage as defined in 42 U.S.C. 18022(d) and (e).

Medical Group: A group of physicians and other health care providers who have organized themselves to provide services to a defined patient population or contract with a Health Issuer or hospital.

Network or Provider Network: The collection of Providers who have entered into contracts with a Health Insurance Issuer which govern payment and other terms of the business relationship between the Health Insurance Issuer and the Providers. Provider Networks are integral to an Issuer's proposed QHPs.

POS: Point of Service as defined in Health & Safety Code 1374.60.

Patient-Centered Medical Home: a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.

Preferred Provider Organization: A network of medical doctors, hospitals, and other health care providers who have contracted with a Health Insurance Issuer to provide health care at reduced rates to the Issuer's insureds or enrollees.

Provider or Network Provider: An appropriately credentialed or licensed individual, facility, agency, institution, organization or other entity that has a written agreement with a proposed QHP Bidder for the delivery of health care services.

QHP Issuer: A Health Insurance Issuer whose proposed QHP has been selected and certified by the Exchange for offering to Qualified Individuals and Qualified Employers purchasing health insurance coverage through the Exchange

Qualified Employer: Qualified Employer has the same meaning as that term is defined in 42 U.S.C. 18032(f)(2) and 45 C.F.R. 155.710.

Qualified Health Plan (QHP): Qualified Health Plan (QHP) has the same meaning as that term is defined in Patient Protection and Affordable Care Act Section 1301, 42 U.S.C. 18021. If a Standalone Dental Plan is offered through the Exchange, another health plan offered through the Exchange shall not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the standalone plan under 42 U.S.C. 18022(b)(1)(J).

Qualified Health Plan Solicitation or Solicitation: The final Exchange QHP Solicitation document released November 16, 2012, labeled the California Health Benefit Exchange 2012-13 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond, and used to solicit responses from Health Insurance Issuers that wish to propose QHPs to be certified by the Exchange to offer market and sell coverage to individuals and employers through the Exchange.

Qualified Individual: Qualified Individual is an individual who meets the requirements of 42 U.S.C. 18032(f)(1) and 45 C.F.R. 155.305(a).

Quality Assurance: Processes used by proposed QHPs to monitor and improve the quality of care provided to enrollees.

Rating Region: The geographic regions for purposes of rating defined in Health & Safety Code 1357.512 and Insurance Code 10753.14.

SHOP Plan Year: A 12-month period beginning with the Qualified Employer's effective date of coverage.

Solicitation Official: The Exchange's single point of contact for the Solicitation.

Standalone Dental Plan: A plan providing limited scope dental benefits as defined in 26 U.S.C. 9832(c)(2)(A), including the pediatric dental benefits meeting the requirements of 42 U.S.C. 18022(b)(1)(J).

Standardized QHP Benefit Design(s): Benefit plan designs that the Board determines to be standard pursuant to Government Code 100504(c), as described in Solicitation Section II.B.1.

State Health Insurance Regulators: The Department of Managed Health Care and California Department of Insurance.

State Mandates: Health care benefits required to be covered by California statutes.

Telemedicine: The ability of physicians and patients to connect via technology other than through Virtual Interactive Physician/Patient capabilities, especially enabling rural and out-of-area patients to be seen by specialists remotely.

Two-Tiered Network: A benefit design with two in-network benefit levels. Standard plan cost-share is applied to most cost-effective network with higher cost-share allowed for more expensive in-network choice. Actuarial value is based on likely overall use of tiered networks.

Value-Based Insurance Design: Value-Based Benefit Design includes explicit use of plan incentives to encourage enrollee adoption of one or more of the following: appropriate use of high-value services, including certain prescription drugs and preventive services and use of high-performance providers who adhere to evidence-based treatment guidelines.

Authority: Gov. Code §§ 100502, 100503, 100504, 100505
Reference: Gov. Code §§ 1005001, 100502, 100503, 100505

ARTICLE 3: COMPETITIVE PROCESS FOR SELECTING QUALIFIED HEALTH PLANS

SECTION 6420: 2012-2013 QUALIFIED HEALTH PLAN SOLICITATION

(a) Qualified Health Plan Solicitation. The Exchange will solicit bids from Health Insurance Issuers to offer, market, and sell QHPs through the Exchange beginning in the Initial Open Enrollment Period. The Exchange will exercise its statutory authority as an "active purchaser" to review submitted bids and reserves the right to select or reject any Bidder or to cancel the Solicitation at any time for any reason. The Qualified Health Plan Solicitation is hereby incorporated by reference.

(1) Bidders must be available before selection and certification by the Exchange to offer their QHPs to start working with the Exchange to establish all operational procedures necessary to integrate and test data interfaces with CalHEERS, and to provide any additional information necessary for the Exchange to market, to enroll members, and to provide QHP services effective January 1, 2014.

Authority: Gov. Code §§ 100503, 100504, 100505
Reference: Gov. Code §§ 100503, 100505

SECTION 6422: BIDDER REQUIREMENTS

Health Insurance Issuers interested in offering, marketing, and selling QHPs through the Exchange must comply with and respond to the questions and information requested in the Qualified Health Plan Solicitation, Section II, Technical Requirements, including appendices attached thereto. A Health Insurance Issuer must comply with Section II. Technical Requirements of the Qualified Health Plan Solicitation and meet all of the criteria listed in this Article in order to submit a bid in response to the Solicitation.

Authority: Gov. Code §§ 100503, 100504
Reference: Gov. Code §§ 100503, 100507; 42 U.S.C. § 18021; 45 C.F.R. § 156.200

SECTION 6424: PROPOSAL PREPARATION INSTRUCTIONS

(a) Final response format and content

(1) For the development and presentation of response data, Bidders must adhere to all format instructions required by the Exchange in Solicitation Section III.

(2) Notwithstanding the above, a Bidder may explain in its response why it cannot respond to any given question or section of the Solicitation. The Exchange reserves the right to accept or reject such explanations at its sole discretion.

(3) The Exchange will make the entire Solicitation available through an Internet Web Portal where Bidders are required to submit their responses. Bidders' entire response must be submitted electronically. The Exchange will assign Bidders a login identification to access the Internet Web Portal. Each Bidder must identify a primary Solicitation respondent, but that individual may, in turn, designate internal subject matter experts for responding. Bidders must participate in two training sessions conducted by the Exchange in order to submit a response to the Solicitation. The Exchange will provide Bidders with written documentation in support of their use of the Internet Web Portal at the training sessions.

(b) General instructions

(1) Each Bidder is limited to a submission of a single response to the Solicitation. For the purposes of this paragraph, "Bidder" includes a parent corporation of a Bidder and any other subsidiary of that parent corporation. If a Bidder submits more than one response, the Exchange will reject all responses submitted by that Bidder.

(2) Before submitting a response, Bidders may seek timely written clarification of any requirements or instructions in the Solicitation by submitting a written inquiry to the Exchange. Bidders must make these inquiries during the timeframe outlined in the Solicitation timeline in Section I.H. of the Solicitation.

(3) Bidders' responses must be delivered to the Solicitation Official by the date and time listed in Solicitation Section I.H. under Key Action Dates for response submission.

(4) Bidders' responses must be submitted in phases as indicated by the Exchange in Solicitation Section I.H.

Authority: Gov. Code §§ 100502, 100504, 100505
Reference: Gov. Code §§ 100502, 100505

SECTION 6440: EVALUATION

(a) Initial Selection: During initial selection, the Exchange Evaluation Team will check each response in detail to determine its compliance with the requirements in this Article. Failure to respond to or meet a mandatory requirement may result in the Exchange considering a Bidder's final response as non-responsive.

(b) Evaluation of Issuers: the Exchange Evaluation Team will consider the mix of QHPs that best meet the Exchange's goal of providing an appropriate range of high-quality choice to participants at the best available price in every part of California. Through its evaluation process, the Exchange will give greater consideration to proposed QHPs that promote the following:

(1) Affordability for the consumer and small employer – both in terms of premium and at point of care.

(2) "Value" competition based upon quality, service, and price.

(3) Competition based upon meaningful QHP choice and product differentiation.

(4) Competition throughout the state.

(5) Alignment with providers and delivery systems that serve the low-income population.

(6) Delivery system improvement, effective prevention programs and payment reform.

(7) Long-term partnerships between the Exchange and Health Insurance Issuers.

Authority: Gov. Code §§ 100502, 100503, 100504, 100505
Reference: Gov. Code §§ 100502, 100503, 100505

SECTION 6442: QHP CERTIFICATION

The Exchange will provide each successful Bidder with a certification that each health plan it offers in the Exchange is a QHP.

Authority: Gov. Code §§ 100502, 100504.
Reference: Gov. Code §§ 100502, 100503; 42 U.S.C. § 18031; 45 C.F.R. 156.200.

SECTION 6444: PROTEST PROCESS

(a) If a Bidder has submitted a proposal which it believes to be totally responsive to the Solicitation's requirements and believes the Bidder should have been selected as a successful Bidder, the Bidder may submit a protest of the selection as described below.

(b) All protests must be made in writing, signed by an individual who is authorized to contractually bind the Bidder, and contain a statement of the reason(s) for protest, citing the law, rule, regulation or procedure on which the protest is based. The Bidder must provide facts and evidence to support its claim. The Bidder must send its protest by certified or registered mail, unless delivered in person, in which case the protester should obtain a receipt of delivery. The Exchange must receive all protests by 5:00 pm on the fifth (5th) calendar day following Bidder selection.

(c) Protests must be mailed or delivered to:

California Health Benefit Exchange
Attn: Executive Director
560 J Street, Suite 290
Sacramento, CA 95814

(d) Protests will be heard and resolved by the Executive Director's designee.

Authority: Gov. Code §§ 100502, 100504, 100505
Reference: Gov. Code §§ 100502, 100505

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT

(REGULATIONS AND ORDERS)

STD. 399 (REV. 12/2008)

See SAM Section 6601 - 6616 for Instructions and Code Citations

DEPARTMENT NAME	CONTACT PERSON	TELEPHONE NUMBER
California Health Benefit Exchange	David Maxwell-Jolly	916.323.3626
DESCRIPTIVE TITLE FROM NOTICE REGISTER OR FORM 400		**NOTICE FILE NUMBER**
Title 10: Process for Selecting Qualified Health Plans for the Exchange		Z

ECONOMIC IMPACT STATEMENT

A. ESTIMATED PRIVATE SECTOR COST IMPACTS (Include calculations and assumptions in the rulemaking record.)

1. Check the appropriate box(es) below to indicate whether this regulation:

- ☐ a. Impacts businesses and/or employees
- ☐ b. Impacts small businesses
- ☐ c. Impacts jobs or occupations
- ☐ d. Impacts California competitiveness
- ☐ e. Imposes reporting requirements
- ☐ f. Imposes prescriptive instead of performance
- ☐ g. Impacts individuals
- ☐ h. None of the above (Explain below. Complete the Fiscal Impact Statement as appropriate.)

h. (cont.) _____

(If any box in Items 1 a through g is checked, complete this Economic Impact Statement.)

2. Enter the total number of businesses impacted: _____ Describe the types of businesses (Include nonprofits.): _____

Enter the number or percentage of total businesses impacted that are small businesses: _____

3. Enter the number of businesses that will be created: _____ eliminated: _____

Explain: _____

4. Indicate the geographic extent of impacts: ☐ Statewide ☐ Local or regional (List areas.): _____

5. Enter the number of jobs created: _____ or eliminated: _____ Describe the types of jobs or occupations impacted: _____

6. Will the regulation affect the ability of California businesses to compete with other states by making it more costly to produce goods or services here?

☐ Yes ☐ No If yes, explain briefly: _____

B. ESTIMATED COSTS (Include calculations and assumptions in the rulemaking record.)

1. What are the total statewide dollar costs that businesses and individuals may incur to comply with this regulation over its lifetime? $ _____

a. Initial costs for a small business: $ _____ Annual ongoing costs: $ _____ Years: _____

b. Initial costs for a typical business: $ _____ Annual ongoing costs: $ _____ Years: _____

c. Initial costs for an individual: $ _____ Annual ongoing costs: $ _____ Years: _____

d. Describe other economic costs that may occur: _____

ECONOMIC AND FISCAL IMPACT STATEMENT cont. (STD. 399, Rev. 12/2008)

2. If multiple industries are impacted, enter the share of total costs for each industry: _____

_____

3. If the regulation imposes reporting requirements, enter the annual costs a typical business may incur to comply with these requirements. (Include the dollar costs to do programming, record keeping, reporting, and other paperwork, whether or not the paperwork must be submitted.): $ _____

4. Will this regulation directly impact housing costs? ☐ Yes ☐ No If yes, enter the annual dollar cost per housing unit: _____ and the number of units: _____

5. Are there comparable Federal regulations? ☐ Yes ☐ No Explain the need for State regulation given the existence or absence of Federal regulations: _____

Enter any additional costs to businesses and/or individuals that may be due to State - Federal differences: $ _____

C. ESTIMATED BENEFITS (Estimation of the dollar value of benefits is not specifically required by rulemaking law, but encouraged.)

1. Briefly summarize the benefits that may result from this regulation and who will benefit: _____

_____

_____

2. Are the benefits the result of : ☐ specific statutory requirements, or ☐ goals developed by the agency based on broad statutory authority?

Explain: _____

3. What are the total statewide benefits from this regulation over its lifetime? $ _____

D. ALTERNATIVES TO THE REGULATION (Include calculations and assumptions in the rulemaking record. Estimation of the dollar value of benefits is not specifically required by rulemaking law, but encouraged.)

1. List alternatives considered and describe them below. If no alternatives were considered, explain why not: _____

_____

_____

2. Summarize the total statewide costs and benefits from this regulation and each alternative considered:

Regulation:	Benefit: $_____	Cost: $_____
Alternative 1:	Benefit: $_____	Cost: $_____
Alternative 2:	Benefit: $_____	Cost: $_____

3. Briefly discuss any quantification issues that are relevant to a comparison of estimated costs and benefits for this regulation or alternatives: _____

_____

_____

4. Rulemaking law requires agencies to consider performance standards as an alternative, if a regulation mandates the use of specific technologies or equipment, or prescribes specific actions or procedures. Were performance standards considered to lower compliance costs? ☐ Yes ☐ No

Explain: _____

E. MAJOR REGULATIONS (Include calculations and assumptions in the rulemaking record.) Cal/EPA boards, offices, and departments are subject to the following additional requirements per Health and Safety Code section 57005.

ECONOMIC AND FISCAL IMPACT STATEMENT cont. (STD. 399, Rev. 12/2008)

1. Will the estimated costs of this regulation to California business enterprises exceed $10 million ? ☐ Yes ☐ No (If No, skip the rest of this section.)

2. Briefly describe each equally as an effective alternative, or combination of alternatives, for which a cost-effectiveness analysis was performed:

   Alternative 1: _____

   Alternative 2: _____

3. For the regulation, and each alternative just described, enter the estimated total cost and overall cost-effectiveness ratio:

   Regulation: $ _____ Cost-effectiveness ratio: $ _____

   Alternative 1: $ _____ Cost-effectiveness ratio: $ _____

   Alternative 2: $ _____ Cost-effectiveness ratio: $ _____

FISCAL IMPACT STATEMENT

A. FISCAL EFFECT ON LOCAL GOVERNMENT (Indicate appropriate boxes1 through 6 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.)

☐ 1. Additional expenditures of approximately $ _____ in the current State Fiscal Year which are reimbursable by the State pursuant to Section 6 of Article XIII B of the California Constitution and Sections 17500 et seq. of the Government Code. Funding for this reimbursement:

   ☐ a. is provided in _____, Budget Act of _____ or Chapter _____, Statutes of _____

   ☐ b. will be requested in the _____ (FISCAL YEAR) Governor's Budget for appropriation in Budget Act of _____

☐ 2. Additional expenditures of approximately $ _____ in the current State Fiscal Year which are not reimbursable by the State pursuant to Section 6 of Article XIII B of the California Constitution and Sections 17500 et seq. of the Government Code because this regulation:

   ☐ a. implements the Federal mandate contained in _____

   ☐ b. implements the court mandate set forth by the _____

   court in the case of _____ vs. _____

   ☐ c. implements a mandate of the people of this State expressed in their approval of Proposition No. _____ at the _____ (DATE) election;

   ☐ d. is issued only in response to a specific request from the _____

   _____, which is/are the only local entity(s) affected;

   ☐ e. will be fully financed from the _____ (FEES, REVENUE, ETC.) authorized by Section

   _____ of the _____ Code;

   ☐ f. provides for savings to each affected unit of local government which will, at a minimum, offset any additional costs to each such unit;

   ☐ g. creates, eliminates, or changes the penalty for a new crime or infraction contained in _____

☐ 3. Savings of approximately $ _____ annually.

☐ 4. No additional costs or savings because this regulation makes only technical, non-substantive or clarifying changes to current law regulations.

ECONOMIC AND FISCAL IMPACT STATEMENT cont. (STD. 399, Rev. 12/2008)

☒ 5. No fiscal impact exists because this regulation does not affect any local entity or program.

☐ 6. Other.

B. FISCAL EFFECT ON STATE GOVERNMENT (Indicate appropriate boxes 1 through 4 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.)

☐ 1. Additional expenditures of approximately $ _____ in the current State Fiscal Year. It is anticipated that State agencies will:

- ☐ a. be able to absorb these additional costs within their existing budgets and resources.
- ☐ b. request an increase in the currently authorized budget level for the _____ fiscal year.

☐ 2. Savings of approximately $ _____ in the current State Fiscal Year.

☑ 3. No fiscal impact exists because this regulation does not affect any State agency or program.

☐ 4. Other.

C. FISCAL EFFECT ON FEDERAL FUNDING OF STATE PROGRAMS (Indicate appropriate boxes1 through 4 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.)

☑ 1. Additional expenditures of approximately $ $245K in the current State Fiscal Year.

☐ 2. Savings of of approximately $ _____ in the current State Fiscal Year.

☐ 3. No fiscal impact exists because this regulation does not affect any federally funded State agency or program.

☑ 4. Other. Assumptions and fiscal statement for subsequent years attached.

FISCAL OFFICER SIGNATURE		DATE Nov 13th, 2012
AGENCY SECRETARY [1] APPROVAL/CONCURRENCE		DATE
DEPARTMENT OF FINANCE [2] APPROVAL/CONCURRENCE	PROGRAM BUDGET MANAGER	DATE

1. *The signature attests that the agency has completed the STD.399 according to the instructions in SAM sections 6601-6616, and understands the impacts of the proposed rulemaking. State boards, offices, or department not under an Agency Secretary must have the form signed by the highest ranking official in the organization.*

2. *Finance approval and signature is required when SAM sections 6601-6616 require completion of Fiscal Impact Statement in the STD.399.*

Assumptions:

- Health Benefit Exchange will receive federal grant funds to support operations through Dec 2014.
- Starting in Jan 2015, the Exchange will be financially self-sustaining
- State general funds will not be used to support Exchange activities

Health Plan Management & CMO

Expenditure Category	Current	2013	2014	TOTAL
Salaries	157,376	314,751	328,343	800,470
Benefits	61,377	122,753	128,054	312,184
OE&E	27,125	54,250	56,000	137,375
Sub-Total	245,878	491,757	512,400	1,250,035
				0
Contractual		326,438	326,437	652,875
TOTAL	**$245,878**	**$818,195**	**$838,837**	**$1,902,910**